Revision: April 5, 2012

837 Health Care Claim:
Dental
ASC X12N 837D (Version 005010A2)

Companion Guide
Final

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1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) - requires health-insurance payers in the United States to comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS).

The standard adopted by the Health Safety Net (HSN) effective January 1, 2012, will follow the same guideline for electronic health care transactions is ANSI ASC X12N Version 005010 as closely as possible. The unique version/release/industry identifier code for the 837 Health Care Claim Dental transaction is 005010X224A1.

1.2 Purpose of the Implementation Guide

The Implementation Guide specifies in detail the required formats for transactions submitted electronically to an insurance company, health-care payer or government agency. The Implementation Guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their submitters. It is critical that your IT staff, or software vendor, review this document in its entirety and follow the stated requirements to submit HIPAA-compliant files to the HSN.

1.3 How to Obtain Copies of the Implementation Guides

The Implementation Guides for X12N, and all other HIPAA standard transactions, are available electronically at www.wpc-edi.com/HIPAA. HSN specific Implementation Guides are available for download on the HSN website www.mass.gov/healthsafetynet.

1.4 Purpose of this Companion Guide

The HSN created this companion guide for HSN trading partners to supplement the X12N Implementation Guide. This guide contains HSN-specific instructions related to the following:

Data formats, content, codes, business rules, and characteristics of the electronic transaction

Technical requirements and transmission options

Information on testing procedures that each trading partner must complete before submitting electronic transactions

The information in this document supersedes all previous communications from the HSN regarding this electronic transaction. The following standards are in addition to those outlined in the provider manuals. These standards in no way supersede HSN regulations and this guide should be used in conjunction with the information found on the HSN website www.mass.gov/healthsafetynet **.**

1.5 Intended Audience

The intended audience for this document is the technical and operational staff responsible for generating, receiving and reviewing electronic health care transactions.

2.0 Establishing Connectivity with HSN

All HSN trading partners are required to sign a trading partner agreement (TPA). If you have elected to utilize a third party to perform electronic transactions on your behalf, you will also be required to complete a trading partner profile (TPP). If you have already completed these forms, you will not be required to complete them again. Please contact HSN Help Desk at 1-800-609-7232 or via email at dhcfphelpdesk@state.ma.us (refer to Section 2.5 - Support Contact Information) if you have any questions regarding these forms.

2.1 Setup

HSN trading partners must submit electronic health care transactions to HSN using our SENDS encryption/decryption application and INET process.

After establishing the transmission method, each trading partner must successfully complete testing. Information on this phase is provided in the next section of this companion guide (refer to Section 2.2 - Trading Partner Testing). After successful completion of testing, transactions may be submitted for production processing.

2.2 Trading Partner Testing

Before submitting production transactions to HSN, each trading partner must complete testing. All trading partners who plan to submit transactions must contact HSN Claims Customer Support Center at 1-866-697-6080 or via email at HSNHelpLine@PublicSectorPartners.com in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

All testing must occur through our INET Application. By using INET you can get a faster response on the status of your claims (e.g., if they have been accepted for payment or denied; if denied, with what error codes), so you can determine the problem and be able to resubmit the claims electronically in a more timely manner.

If you are a first-time submitter and want to test electronically with HSN we require the following.

The test file must have a minimum of 10 and a maximum of 50 test claims.

The member and provider data must be valid for a mutually agreed upon effective date.

> ***The test files should contain as many types of claims as necessary to cover each of your business scenarios.***

The following conditions must be addressed in one or more test files.

- Original claims;
- Void claims (if you plan to submit void transactions);
- Replacement claims (if you plan to submit void transactions and replacement claims); and

COB claims testing is required for providers who plan to submit COB claims. Providers submitting test files containing COB claims (where the member has other insurance) should include a minimum of 10 and a maximum of 50 COB claims with the following criteria.

- Claims with commercial insurance (denied/paid);
- Claims with Medicare (denied/paid);

- Claims with Medicaid (denied/paid);
- Claims with Medicare/Medicaid (denied/paid); and
- Claims with multiple insurance (if applicable)

HSN will process these transactions in a test environment to validate that the file structure and content meet HIPAA standards and HSN-specific data requirements. Once this validation is complete, the trading partner may submit production 837D transactions to HSN for adjudication. Test claims are adjudicated in the test system, but will not be adjudicated for payment.

2.3 Technical Requirements

The current maximum file size for any file submitted to HSN is **16 MB**. Additionally, there is only one ST-SE and GS-GE envelope permitted per submission. If you have any questions, or would like to coordinate the processing of larger files, please contact HSN Help Desk at 1-866-697-6080 or via email at HSNHelpLine@PublicSectorPartners.com (refer to Section 2.5 - Support Contact Information).

2.4 Acknowledgements

Confirmation numbers are generated for all transaction files successfully uploaded to the INET Application, indicating successful file uploads. HSN does not utilize the 997, 276/277 transaction sets at this time.

2.5 Support Contact Information

All hard media containing signatory forms or claims for Claims Denial Review must be mailed to the following address.

Division of Health Care Finance & Policy
Health Safety Net
2 Boylston Street, 4th Floor
Boston, MA 02116
E-mail: dhcfphelpdesk@state.ma.us
Phone: 1-800-609-7232

3.0 HSN-specific Submission Requirements

The following information is for production claims. For test claims, refer to the Trading Partner Testing section.

The following sections outline recommendations, instructions, and conditional data requirements for 837D claims submitted to HSN. This information is designed to help trading partners construct 837 transactions in a manner that will allow HSN to efficiently process claims.

HSN expects the provider's national provider identifier (NPI) in the appropriate NM109 data element, and taxonomy code in the appropriate PRV data element.

HSN expects the billing provider identification, and also doing business address (DBA), to be the billing provider address and ignores the 2010AB loop.

3.1 Claims Attachments

An electronic standard for claims attachments has not been finalized by the Centers for Medicare & Medicaid Services (CMS). Until then, HSN will not recognize any attachments utilized in the transaction set

Note: "Attachments" does not refer to COB attachments such as an EOB from another insurer. See Section 3.3 - Coordination of Benefits for more information.

3.2 Encounter Claims

HSN does not accept encounter claims. For further details, see Section 3.6 - Detail Data.

3.3 Coordination of Benefits

The implementation of the 837 transaction enables providers to submit claims for members with other insurance electronically to HSN, after billing all other resources. When submitting an 837 transaction to HSN for members with other insurance, providers must supply the other payer's adjudication details that were provided on that insurer's 835 or paper remittance transaction. Providers are required to enter the other payer's adjudication details at the claim level. Line-level adjudication details are required for outpatient claims.

The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer. Altering the adjudication details given by the other payer is considered fraudulent.

In addition, since the national plan ID is not mandated yet, HSN requires providers to enter the HSN-assigned carrier code on the 837 transaction to identify the other insurance. A list of carriers with the applicable code can be found on the HSN website www.mass.gov/healthsafetynet .

After billing all resources before billing HSN, enter the other payer's carrier code number on the 837 transaction. See Section 3.7 - Detail Data for COB Claims for more details.

3.3.1 COB Bundled Claims

HSN processes claims for services that are bundled by a commercial insurance, Medicare or MassHealth as a bundled claim. If you need to correct a bundled claim, you can make the necessary changes and resubmit the claim or you can void the claim, make the necessary corrections to the claim, and resubmit the bundled claim as an original 837 transaction.

Whenever HSN requires HCPCS and or revenue codes for billing, follow the HSN rules and submit the applicable HCPCS and or revenue codes for all COB claims including crossovers.

3.3.2 COB Claims with Medicare

After Medicare has made a payment or applied the charge to the deductible, claims can be forwarded to HSN for secondary adjudication of deductibles, copays and coinsurances when HSN is the next and last payer of resort.

Please refer to all other prior payer manuals for billing guidelines before submitting HSN Secondary to Medicare or after Medicare/MassHealth combination claims to HSN.

3.3.3 COB Balancing

Payer Paid Amount Balancing - Payer paid amount on all claims submitted to HSN must balance at both the service line and the claim level. For each payer, the total claim payer paid amount must balance to the sum of all service line payer paid amounts less the claim level adjustment reason code amounts.

For claim types C (outpatient Part B crossover), and O (hospital outpatient), for each payer, the sum of service line payer paid amount and service line adjustment reason code amounts should balance to the provider billed amount on the service line.

For claim types A (Part A crossover), and I (Hospital Inpatient), for each payer, the sum of the payer paid amount and adjustment reason code amounts at the claim level should balance to the provider billed amount at the claim level.

3.4 340B Drug Information

In order for providers to identify 340B drugs dispensed in an outpatient or clinic setting, the National Medicaid Electronic Data Interchange HIPAA workgroup has recommended use of the UD modifier.

The UD modifier should be associated with the applicable HCPCS code (and NDC) to properly identify 340B drugs reported on the 837P.

3.5 Void Transactions

Void transactions are used by submitters to correct and report any one of the following situations.

- Duplicate claims erroneously paid
- Payment to the wrong provider
- Payment for the wrong member
- Payment for overstated or understated services
- Payment for services for which payment has been received from third-party payers

Void transactions must be submitted at the claim-header level and must include the original Patient Account Number for the service with a claim frequency code equal to “8.”

3.6 Replacement Transactions

Replacement transactions are used by submitters to adjust paid claims. If the submitter is trying to correct a paid claim where the member ID, provider ID, and claim type are staying the same, they can send in a

replacement claim with appropriate lines from the original claim (both paid and denied). All lines must be resubmitted. Add additional lines if necessary or correct data elements on existing detail lines as appropriate. Replacement transactions must include the original Patient Account Number for the service with a claim frequency code equal to "7."

Please note that a submitter should not attempt to void the original claim before sending in a replacement. This will result in denial of the replacement claim for Original Claim not Found. Instead, the submitter should send in only the replacement transaction. The system will automatically inactivate the original claim.

3.7 Production File-naming Convention

837 files transmitted to HSN using SENDS may use any convenient file-naming convention. Once the file is processed into the INET application, the system will rename files upon receipt and issue a tracking number for reference, referred to as a Submission Control ID.

3.8 Transaction Set

3.8.1 Interchange Control and Functional Group Header

Loop	Segment	Element Name	Companion Information
	ISA01	**Authorization Information Qualifier**	**00**
	ISA02	**Authorization Information**	**10 blanks**
	ISA03	**Security Information Qualifier**	**00**
	ISA04	**Security Information**	**10 blanks**
	ISA05	**Interchange ID Qualifier**	**ZZ**
	ISA06	**Interchange Sender ID**	**Trading Partner ID assigned by HSN (OrgID)**
	ISA07	**Interchange ID Qualifier**	**ZZ**
	ISA08	**Interchange Receiver ID**	**HSN3644**
	ISA09	**Interchange Date**	**YYMMDD format**
	ISA10	**Interchange Time**	**HHMM format**
	ISA11	**Repetition**	**^**
	ISA12	**Interchange Control Version Number**	**00501**
	ISA13	**Interchange Control Number**	**Must match Interchange Control Trailer IEA02**
	ISA14	**Acknowledgement Requested**	**0**
	ISA15	**Interchange Usage Indicator**	**P = Production T = Test**
	ISA16	**Component Element Separator**	**:**

Loop	Segment	Element Name	Companion Information
	GS01	Functional Identifier Code	HC
	GS02	Application Sender's Code	Trading Partner ID assigned by HSN (OrgID)
	GS03	Application Receiver's Code	HSN3644
	GS04	Date	CCYYMMDD format
	GS05	Time	HHMM format
	GS06	Group Control Number	Must match Function Group Trailer GE02
	GS07	Responsible Agency Code	X
	GS08	Version / Release Identifier Code	005010X224A2

3.8.2 Segment Detail for Standard Claims

Loop	Segment	Element Name	Companion Information
	ST03	Implementation Convention Reference	005010X224A2
	BHT04	Date	Enter date billed
	BHT06	Transaction Type Code	CH
1000A	NM109	Submitter Identification Code	Trading Partner ID assigned by HSN (OrgID)
1000B	NM109	Receiver Identification Code	HSN3644
2000A	PRV01	Provider Code	BI
2000A	PRV02	Reference Number Qualifier	PXC
2000A	PRV03	Provider Taxonomy Code	Report Billing Provider Dental Taxonomy 126800000X = Dental Assistant 124Q00000X = Dental Hygienist 126900000X = Dental Laboratory Technician 122300000X = Dentist 1223D0001X = Dental Public Health 1223E0200X = Endodontics 1223G0001X = General Practice 1223P0106X = Oral & Maxillofacial Pathology 1223X0008X = Oral & Maxillofacial Radiology 1223S0112X = Oral & Maxillofacial Surgery 1223X0400X = Orthodontics & Dentofacial Orthodontics 1223P0221X = Pediatric Dentistry 1223P0300X = Periodontics 1223P0700X = Prosthodontics 122400000X = Denturist
2010AA	NM108	Identification Code Qualifier	XX
2010AA	NM109	Identification Code	Report Billing Provider NPI

Loop	Segment	Element Name	Companion Information
2010AA	**REF01**	**Reference Identification Qualifier**	**EI**
2010AA	**REF02**	**Billing Provider Identifier**	**Report Employer Identification Number**
2000B	**SBR01**	**Payer Responsibility Sequence Number Code**	**P = HSN is Primary** **S = HSN is Secondary** **T = HSN is Payer of Last Resort when more than two prior payers are present on claim**
2000B	**SBR02**	**Individual Relationship Code**	**18**
2000B	**SBR03**	**Reference Identification**	**Element must be blank**
2000B	**SBR04**	**Name**	**Prime = HSN is the sole payer (SBR01 = P)** **Second = HSN is both the secondary and last payer (SBR01 = S or T)** **Partial = HSN will pay for a portion of the claim after certain subscriber responsibility (SBR01 = P, S or T)** **BD = Subscriber has no HSN or MassHealth Eligibility and is being billed for ER Bad Debt (SBR01 = P)** **CA = Subscriber may have other coverage but requires anonymity (SBR01 = P, S or T); requires Application number reporting in Loop 2300 REF02 where REF01 = G1** **MH = Subscriber has no HSN Eligibility and has financial aid with medical expenses (SBR01 = P, S or T); requires Application number reporting in Loop 2300 REF02 where REF01 = G1**
2000B	**SBR09**	**Subscriber Information Claim Filing Indicator Code**	**ZZ**
2010BA	**NM108**	**Identification Code Qualifier**	**MI when reporting MassHealth RID or Default number, else do not report**
2010BA	**NM109**	**Subscriber Identification Code**	**Report the 12-character MassHealth member's recipient identification number (RID) when Subscriber has HSN Eligibility;** **else report 000000000001, a 12-character default number when HSN BD, CA or MH eligible OR leave blank**
2010BA	**REF01**	**Reference Identification Qualifier**	**SY**

Loop	Segment	Element Name	Companion Information
2010BA	REF02	Subscriber Secondary Identification Code	Report the Subscriber's SSN; else report 000000001
2010BB	NM108	Identification Code Qualifier	PI
2010BB	NM109	Payer ID Code	995
2300	CLM01	Claim Submitter's Identifier	Report only unique Patient Control Numbers that do not enumerate with Rebills and/or Voids
2300	CLM02	Monetary Amount	Only positive amounts allowed; must equal the sum of all line charge amounts
2300	CLM05-1	Facility Code Value	03 = School 04 = Homeless Shelter 11 = Office 15 = Mobile Unit 20 = Urgent Care Facility 21 = Inpatient Hospital 22 = Outpatient Hospital No other facility values accepted by HSN
2300	CLM05-3	Claim Frequency Type Code	1 = Admit thru Discharge Claim 7 = Replacement Claim 8 = Void Claim No other frequency values accepted by HSN
2300	DTP01	Date/Time Qualifier for Admission Date	472 = Service Date
2300	DTP02	Date Time Period Format Qualifier	D8
2300	DTP03	Date Time Period	CCYYMMDD format
2300	CN101	Contract Type Code	06 = Subscriber with Partial Eligibility 09 = Subscriber with any other HSN Type
2300	CN102	Monetary Amount	HSN Estimated Amount Due Report only valid amounts; no negatives and cannot be greater than the sum of all Claims Lines when SBR01 = P; CN102 is the last element required when SBR01 = P.
2300	CN104	Reference Identification	Open = Partial amount still due; SBR04 = Partial Met = Partial amount has been satisfied; SBR04 = Partial Assist = Provider aided Subscriber with BD Application; SBR04 = BD Blank = Provider did not assist with BD or general HSN Secondary Claim
2300	CN105	Terms Discount	20 = Percentage to be calculated; SBR04 = Partial 100 = Percentage met; SBR04 = Partial
2300	CN106	Version Identifier	Report BD Write-off Date; SBR04 = BD Report Partial Start Date; SBR04 = Partial

Loop	Segment	Element Name	Companion Information
2300	AMT01	Amount Qualifier Code	F5
2300	AMT02	Monetary Amount	Report any amounts paid by Patient (Subscriber)
2300	REF01	Reference Identification Qualifier	G1; segment required when SBR04 = CA or MH
2300	REF02	Reference Identification Code	Report HSN CA/MH Application number
2310B	NM101	Entity Identifier Code for Rendering Provider	82
2310B	NM108	Identification Code Qualifier	XX
2310B	NM109	Identification Code	Enter Attending's NPI
2310B	PRV01	Provider Code	PE
2310B	PRV02	Reference Identification Qualifier	PXC
23010B	PRV03	Reference Identification	Report the Rendering Provider's Taxonomy number
2310B	REF01	Reference Identification Qualifier	0B; required to report BORIM number
2310B	REF02	Reference Identification Code	Report Attending's BORIM number
2310C	NM101	Entity Identifier Code for Service Facility	77
2310C	NM108	Identification Code Qualifier	XX
2310C	NM109	Identification Code	Enter Service Facility's NPI
2310C	N301	Address Information	Report street address of service facility; utilize N302 if applicable
2310C	N401	City Name	Report city of service facility
2310C	N402	State or Province Name	Report state of service facility
2310C	N403	Postal Code	Report zip code of service facility
2310C	REF01	Reference Identification Qualifier	LU
2310C	REF02	Reference Identification Code	Facility ID assigned by HSN (OrgID)

3.8.3 Segment Detail for COB Claims

Loop	Segment	Element Name	Companion Information
2320	SBR01	Payer Responsibility Sequence Number Code	Report valid number code for each payer reported

Loop	Segment	Element Name	Companion Information
2320	SBR09	Claim Filing Indicator Code	Report the valid code that identifies the payer/claim by type
2320	CAS01	Claim Adjustment Group Code	Report the valid group code as received/mapped from prior payer
2320	CAS02	Claim Adjustment Reason Code	Report valid, active codes for the date of service
2320	CAS03	Monetary Amount	Report valid amounts, use decimal when cents are greater than zero
2320	AMT01	Amount Qualifier Code for Prior Payment	D
2320	AMT02	Monetary Amount	Report valid amounts, use decimal when cents are greater than zero. HSN requires full disclosure of any and all payments made to a claim prior to HSN Payment. Report 0 if prior payer paid 0 or if prior payer denied the claim.
2320	AMT01	Amount Qualifier Code for Patient Liability	EAF
2320	AMT02	Monetary Amount	Report valid amounts, use decimal when cents are greater than zero. HSN requires full disclosure of any and all prior adjudication to a claim sent for HSN Payment. Report 0 if prior payer did not process a patient liability or if the claim was denied and there is no patient liability. Non covered charges should be reported under the Noncovered segment.
2320	AMT01	Amount Qualifier Code for Prior Payment	A8
2320	AMT02	Monetary Amount	Report valid amounts, use decimal when cents are greater than zero. HSN requires full disclosure of any and all prior adjudication to a claim sent for HSN Payment. Report 0 if prior payer paid all charges and remaining balance is for Patient Liability else report the total dollars not covered by the prior payer.
2320	OI03	Yes/No Condition code	Report valid values
2320	OI06	Release of Information Code	Report valid values
2320	MOA01 – 09	Medicare Outpatient Adjudication Information	This segment is required when Loop 2330B REF02 = an HSN Medicare Payer code
2330A	NM101	Entity Identifier Code for Other Subscriber	IL
2330A	NM108	Identification Code Qualifier	MI
2330A	NM109	Identification Code	Report Prior Payer's Subscriber identification number
2330A	N301	Address	Report Street Address of Other Subscriber, use N302 if applicable

Loop	Segment	Element Name	Companion Information
2330A	**N401**	**City Name**	**Report city of Other Subscriber**
2330A	**N402**	**State or Province Name**	**Report state of Other Subscriber**
2330A	**N403**	**Postal Code**	**Report zip code of Other Subscriber**
2330A	**REF01**	**Reference Identification Qualifier**	**SY**
2330A	**REF02**	**Reference Identification Code**	**Report Other Subscriber's SSN; else report 000000001**
2330B	**NM101**	**Entity Identifier Code for Other Payer**	**PR**
2330B	**NM108**	**Identification Code Qualifier**	**PI**
2330B	**NM109**	**Identification Code**	**Report Other Payer's identification number; typically an EDI clearinghouse identifier**
2330B	**DTP01**	**Date / Time Qualifier for Adjudication Date**	**573**
2330B	**DTP02**	**Date Time Period Format Qualifier**	**D8**
2330B	**DTP03**	**Date Time Period**	**CCYYMMDD format**
2330B	**REF01**	**Reference Identification Qualifier for Other Payer ID**	**2U**
2330B	**REF02**	**Reference Identification**	**Report HSN Assigned Payer ID that matches the payer identified in Loop 2330B NM103 / NM109**

3.9 Additional Information

HSN does not process certain loops that do not apply to the HSN business model. For example, HSN does not process Patient Hierarchical information (Loop 2000C) since all HSN identification is performed at the Subscriber Level, however if submitted the file will pass but the information will not be stored. In certain circumstances, loops may be required in a compliant 837 transaction. However, the data content of these loops will not affect the HSN claims process.

3.10 Service Codes

Please consult Subchapters 5 and 6 of your MassHealth provider manuals for information on acceptable service codes with supplemental information available on the Web at www.mass.gov/healthsafetynet .

4.0 Sample HSN Transactions

Example of HSN 837D Transaction
[Placeholder – update after testing]

Example of HSN 837D COB Transaction
[Placeholder – update after testing]

5.0 Version Table

Version	Date	Section	Description	Author
1.0	1/15/08	Entire Document	Document is a mimic of the MassHealth Companion Guide with changes for HSN	M. Prettenhofer
3.0	01/15/11	Entire Document	HIPAA Version 5010 Revision 1	M. Prettenhofer
3.0	04/16/11	Entire Document	Align HSN Companion Guide to follow same flow as MassHealth Companion Guide for 837P	M. Prettenhofer
3.0	5/11/11	1.3	HSN website added as reference for HSN Guides	M. Prettenhofer
3.0	5/11/11	5.0 Version Table	Historical pre-5010 version changes removed	M. Prettenhofer
3.0	6/20/11	3.8.2	Removed the requirement to submit Adjudication Date in CN106 when HSN is Secondary	M. Prettenhofer
3.0	7/27/11	Entire Document	DRAFT watermark removed; Title and footers set to Final.	M. Prettenhofer
3.1	4/5/2012	3.8.2	L2010BA NM108 requirement shift from Required to Situational to align with null reporting allowance in NM109	D. Wong
3.1	4/5/2012	3.8.2	L2010BA NM109 requirement shift form Required to Situational to align with null reporting option when HSN is BD, CA or MH	D. Wong

Appendix A: Links to Online Resources

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)
ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

Accredited Standards Committee (ASC X12N)
ASC X12N Develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes. www.x12.org

American Hospital Association Central Office on ICD-9-CM (AHA)
This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level I HCPCS.
www.ahacentraloffice.org

American Medical Association (AMA)
This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Association for Electronic Healthcare Transactions (AFEHCT)
AFEHCT is a health-care association dedicated to promoting the interchange of electronic health-care information. www.himss.org

Centers for Medicare & Medicaid Services (CMS)
CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-care Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/HIPAAGenInfo/ .

This site is the resource for information related to the Health-care Common Procedure Coding System (HCPCS). www.cms.hhs.gov/HCPCSReleaseCodeSets/

Designated Standard Maintenance Organizations (DSMO)
This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org

Division of Health Care Finance & Policy (DHCFP)
This site is a resource for reliable, objective health care information. DHCFP collects a broad and diverse array of data from across the Massachusetts health care landscape - vital resources encompassing claims data, provider cost reports, and hospital case mix records. www.mass.gov/DHCFP

This site is the resource for information directly related to the Health Safety Net
www.mass.gov/healthsafetynet

Health Level Seven (HL7)
HL7 is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards. www.hl7.org

MassHealth
The MassHealth Web site assists providers with HIPAA billing and policy questions, as well as provider enrollment support. www.mass.gov/masshealth

National Council of Prescription Drug Programs (NCPDP)
The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)
NUBC is affiliated with the American Hospital Association and develops standards for institutional claims. www.nubc.org

National Uniform Claim Committee (NUCC)
NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)
OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)
The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)
WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)
WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org